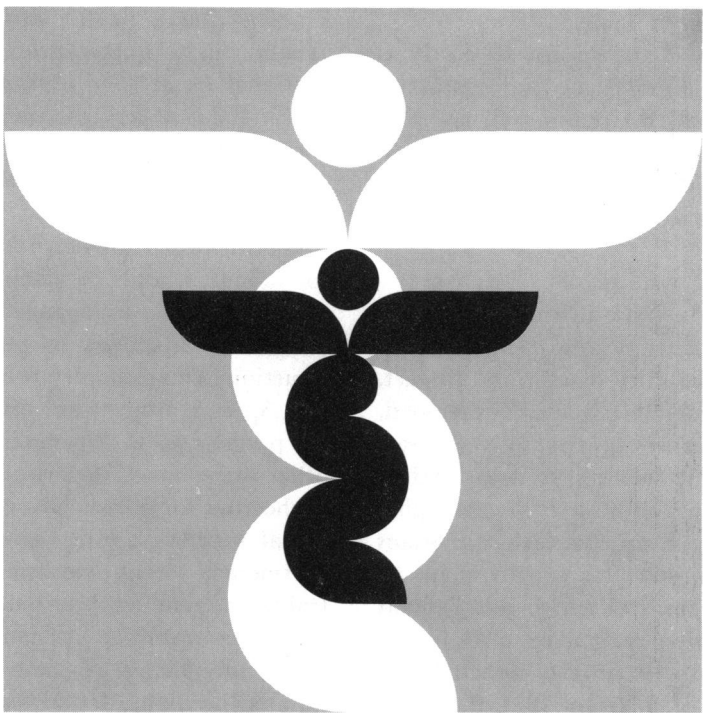
Training the Nation's Health Manpower —The Next 4 Years—



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THE HEALTH PROFESSIONS EDUCATIONAL Assistance Act of 1976 extends Federal support for the training of physicians, dentists, and other health personnel to 1980 with major revisions to meet the nation's changing health manpower needs (*1*). The new law (Public Law 94–484), which amends Title VII of the Public Health Service Act and other laws, is concerned primarily with the kinds of health professionals being trained and where they will practice. Increasing student enrollment, a major reason for instituting the Health Professions Educational Assisting (HPEA) Program in 1963, is no longer a primary objective.

The change in outlook from numbers to types of practitioners emerged during the extensive discussions that preceded enactment of the law on October 12, 1976. During the 3 years of bill introductions, hearings, markups, and debates, Congress reexamined the basic premises of the HPEA Program.

Expanded Capacity

There was substantial agreement that the HPEA Program, under which more than $5 billion had been awarded through fiscal year 1976, had largely succeeded in expanding the capacity of U.S. health professions schools to an adequate level. During the decade from academic years 1967 to 1976, the number of health professions schools increased from 256 to 297. Greatest increases were reported in osteopathy, 100 percent (5 new schools); optometry, 30 percent (3 new schools); and medicine, 24 percent (23 new schools).

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The number of health professions students graduated yearly rose 82 percent between academic years 1966 and 1975 (16,899 to 30,671) (*2*). Gains by professions included pharmacy, 100 percent (3,782 to 7,567); medicine, 79 percent (7,743 to 13,823); and dentistry, 65 percent (3,360 to 5,529).

The ratio of active physicians improved, partly as a result of an influx of foreign medical graduates (FMGs), from 145 per 100,000 population in 1965 to 159 per 100,000 in 1974. Some projections indicated that further expansion of enrollment could produce surpluses of practitioners by 1990.

Worsening Situation

Despite the unparalleled increase in the overall supply of health personnel, there was no proportionate improvement in the availability of services. In fact, most observers found that the situation worsened, especially in rural and inner-city areas. New practitioners tended to move to well-staffed areas and to shun shortage areas. One indicator of this phenomenon is the widening range between the States with the highest and lowest ratios of physicians to population. In 1949 the ratio of active non-Federal MDs per 100,000 population ranged from 64 in the lowest State, Mississippi, to 196 in the highest State, New York, a difference of 132. In 1974 the ratio ranged from 78 in North Dakota to 237 in New York, a difference of 159.

The scarcity of services has been intensified by increasing specialization among practitioners (*3*). General practitioners have declined from 75 percent of the physician work force in 1930 to about 15 percent today. Particularly striking is the decline in the number of office-based physicians in primary care specialties. The trend to specialization also is appearing in dentistry and other health professions.

To address these growing problems, Congress revised the HPEA Program substantially. The major purposes of the new law are to increase the proportion of primary care practitioners and improve the geographic distribution of personnel. Heavy emphasis is put on assistance to students willing to take part in shortage-related activities. Entry of FMGs is restricted. Priorities are more specifically delineated for allied health and public health training.

Summary of the Law

Most existing authorities are extended without change through fiscal year 1977. Most new authorities go into effect in fiscal year 1978 for a 3-year period (*4*). New student assistance programs of insured loans to health professions students, scholarships for first-year health professions students of exceptional need, and Lister Hill Scholarships for medical students are established. The Health Professions Student Loan and Loan Repayment Programs are continued on a more restrictive basis. Unconditional Health Professions Scholarships are phased out. Authorizations are greatly increased for National Health Service Corps (NHSC) Scholarships, and obligated service conditions are broadened to include private practice. The Corps is given greater flexibility, and the definition of shortage areas is widened.

Health professions capitation support is expanded to include schools of public health, and conditions of participation are changed. The construction grant program is amended to provide authority for construction of ambulatory primary care teaching facilities. Special projects are divided into eight categorical programs and a general authority for numerous other programs. Categorical programs consist of new authorities for area health education centers; occupational health training centers; family medicine departments; family medicine and general dentistry training; general internal medicine and general pediatrics training; assistance to disadvantaged students; physician's assistant, expanded function dental auxiliary, and dental team practice support; and assistance to U.S. schools to train Americans who transferred from foreign medical schools. Startup, financial distress, and interdisciplinary training programs are authorized under general special project authority. Special project support will be available for activities formerly carried out under the Health Manpower Education Initiative Award Program, which is being phased out. Authority for grants for conversion of 2-year medical schools to MD degree-granting institutions is repealed in fiscal year 1978. Support is continued for allied and public health training with purposes more precisely specified. Restrictions are tightened on the entry of FMGs.

The HPEA Program provides support for the training of students of medicine, osteopathy, dentistry (MOD), veterinary medicine, optometry, pharmacy, podiatry (VOPP), allied health, and public health. The term "health professions," as defined in the law, refers to the seven MODVOPP disciplines. Some $2.7 billion is authorized for the fiscal year 1977–80 period for HPEA Programs which are administered by the Bureau of Health Manpower. The Bureau is part of the Health Resources Administration, one of the six agencies of the Public Health Service, Department of Health, Education, and Welfare (DHEW).

Primary Care Training

Capitation. After rejecting proposals for direct controls over residency positions, Congress modified the capitation grant program to encourage training of primary care practitioners. Initiated in the Comprehensive Health Manpower Training Act of 1971, the capitation program of basic institutional support is tied to enrollment. It remains the largest single HPEA Program under the new law, carrying appropriation authorizations amounting to $853 million for fiscal years 1977–80, about one-third of the total authorizations. Capitation has been limited to health professions schools but will be expanded in fiscal year 1978 to include schools of public health.

Although schools requested increased capitation, authorizations are continued at a level approximating 22 percent of educational costs. "The vast majority of the schools are not in financial difficulties," the House Interstate and Foreign Commerce Committee observed, noting that there has been a decline in financial distress grant applications since the establishment of capitation (*5*). The financial distress grant program also is continued, but beginning in fiscal year 1978, the amount of a grant is limited to 75 percent of the amount received by the school under this program in the preceding year.

Under the capitation grant program, a school of medicine, osteopathy, or dentistry is authorized to receive up to $2,000 for each full-time student enrolled in the 1978–79 school year; $2,050 for each student enrolled in 1979–80; and $2,100 for each student enrolled in 1980–81. A single annual per-student figure for the 3-year period has been set for other schools eligible for capitation grants: veterinary medicine $1,450, public health $1,400, podiatry $965, optometry $765, and pharmacy $695.

Following are capitation requirements for the various schools.

- To obtain capitation grants beginning in fiscal year 1978, medical schools must have specified percentages of filled first-year residency positions in direct or affiliated residency training programs in primary care. Primary care is defined as general internal medicine, family medicine, or general pediatrics. The required percentages of primary care positions are 35 percent for fiscal year 1978 grants, 40 percent for 1979 grants, and 50 percent for 1980 grants. Unless this requirement is met by a national average of all schools on July 15 before a fiscal year begins, schools individually must meet requirements on July 15 of the following year.
- Dental schools also must promote the training of primary care practitioners as a requirement for capitation awards. They must have at least 70 percent of new filled residency positions over those in the 1977–78 school year in general dentistry or pedodontics. Dental schools also must either increase first-year enrollment or submit approved plans to train students for at least 6 weeks in ambulatory care settings in remote or medically underserved areas. If a school chooses to increase enrollment, it must increase first-year enrollment over that in the 1976–77 school year by 10 percent or, if enrollment exceeds 100, by 5 percent or 10 students, whichever is greater.
- Schools of osteopathic medicine, which produce a high percentage of primary care practitioners, are required, as a condition for capitation, to submit plans to train students in ambulatory care settings either in remote or medically underserved areas. All students must receive at least 6 weeks of this training. Properly designed and supported remote-site training programs are believed to have a positive effect on a student's decision to deliver primary care in rural areas.
- Schools of public health must increase first-year enrollment in the 1978–79 school year by 5 percent over 1976–77. If first-year enrollment exceeds 100, it must be increased by 2.5 percent or 5 students, whichever is greater. A waiver is permitted if compliance would prevent a school from maintaining accreditation.
- Veterinary medical schools must increase first-year enrollment in the 1978–79 school year by 5 percent over 1976–77 (or if enrollment exceeds 100, by 2.5 percent or 5 students, whichever is greater) or enroll at least 30 percent of first-year students from States without an accredited veterinary school. Veterinary schools also must assure that clinical training will emphasize care to food- or fiber-producing animals.
- Optometry schools must increase first-year enrollment in the 1978–79 school year by 5 percent over 1976–77 (or if enrollment exceeds 100, by 2.5 percent or 5 students, whichever is greater) or enroll at least 25 percent (or 50 percent for nonprofit private schools) of first-year students from States without an accredited optometry school.
- Podiatry schools must increase first-year enrollment in the 1978–79 school year by 5 percent over 1976–77 (or if enrollment exceeds 100, by 2.5 percent or 5 students, whichever is greater) or enroll at least 40 percent of first-year students from States without an accredited podiatry school.
- Pharmacy schools must assure that each student will receive training in clinical pharmacy.

Categorical special projects. A number of the new categorical special project authorities are designed to promote the training of primary care practitioners. Beginning in fiscal year 1977, new special project authority is established for grants and contracts to schools of medicine and osteopathy to plan, develop, and operate medical residency programs that emphasize training for practice in general internal medicine or general pediatrics. Traineeships and fellowships are authorized for participating residents.

Beginning in fiscal year 1978, project grants are authorized to schools of medicine and osteopathy to establish academic administrative units to provide clinical instruction in family medicine. Existing grants for family medicine training will be replaced in fiscal year 1978 by a new, expanded program that includes contract authority. Eligibility, currently limited to hospitals, will be broadened to include schools of medicine or osteopathy or other public or private nonprofit entities. Authority is added for training in general dentistry and for training of physicians who plan to teach family medicine. Traineeships and fellowships are authorized. The preceptorship program, under which several thousand medical and dental students have received part of their training from primary care preceptors, may be continued under the broadened family medicine training authority or under a special project authority for health manpower development.

Construction assistance. The primary care emphasis also is reflected in the revised teaching facilities construction and startup programs. The program of matching construction grants is amended in fiscal year 1978 to provide funds to build ambulatory primary care teaching facilities. New authority provides for grants to public and nonprofit private entities to assist in the construction of teaching facilities to train physicians and dentists in ambulatory primary care. Of the total appropriated for construction grants, 50 percent is to be devoted to construction of ambulatory care facilities and 50 percent to the existing program of constructing, expanding, replacing, or renovating teaching facilities of health professions and public health schools. None of the grants for ambulatory facilities may exceed $1 million or 50 percent of the cost of a facility, whichever is less. For fiscal year 1977 only, construction authority is amended to allow clinical facilities affiliated with a school of optometry, pharmacy, podiatry, or veterinary medicine to apply directly for a grant for construction of a facility for the purpose of establishing or expanding a regional health professions program. The program of guarantees and interest subsidies on construction loans from non-Federal lenders to private nonprofit health professions and public health schools is continued and amended.

Startup support. Startup assistance for new schools is broadened in fiscal year 1978 to provide grants to health professions and public health schools. Priority is established for schools of medicine, osteopathy, or dentistry which will conduct exceptionally innovative programs for training in ambulatory primary care or which will have, as a major objective, the provision of training opportunities for disadvantaged persons. Special consideration will be given to schools located in areas with health manpower shortages.

Shortage Area Staffing

The "most critical health manpower issue" faced by Congress in devising new HPEA legislation was the inequitable distribution of health personnel. In search of a way to attract new practitioners to inner-city and rural areas, Congress considered numerous proposals, including some with compulsory features. Congress adopted a voluntary approach that consisted largely of strengthening NHSC and its scholarship program. "The NHSC, coupled with the scholarship program," according to the House Interstate and Foreign Commerce Committee, "represents the most effective legislative mechanism ever developed by the Congress in its attempts to solve the growing problem of geographic maldistribution of health professionals in the United States" (*5*). Several new student assistance programs also were authorized.

National Health Service Corps. The new law extends and amends the authority (in Title III of the Public Health Service Act) to operate the Corps, which is administered by the Health Services Administration. The law broadens the definition of a shortage area to permit assignment of Corps members to a population group with a shortage or to a public or nonprofit private medical facility or other public facility with a shortage. In assigning Corps members, DHEW must give priority to areas with the greatest health manpower shortages. DHEW may waive cost-sharing requirements if it is determined that a community is financially unable to pay. To help establish a practice, the Department may loan a community not more than $50,000 for

such purposes as acquiring equipment and renovating buildings.

NHSC Scholarships. Authorizations for the NHSC Scholarships (formerly PH/NHSC Scholarships) have been raised to the point where the fiscal year 1980 figure of $200 million amounts almost to a ninefold increase over fiscal year 1976 funding of $22.5 million. Eligibility, now limited in practice to students of medicine, osteopathy, dentistry, and nursing, may be expanded, if needed by the Corps, to other health occupations including physician's assistants, nurse practitioners, and expanded function dental auxiliaries. The amount of stipend for living expenses is changed in fiscal year 1978 to $400 a month with provision for annual increases. Tuition and other reasonable educational expenses also are paid. Participants are required to perform obligated service on a year-for-year basis with a minimum of 2 years. Obligated service is to be performed as a commissioned or civilian member of the Corps or, under specified conditions, in private practice in a shortage area. The penalty for failure to perform obligated service is increased to three times the amount of scholarship assistance, plus interest at the maximum prevailing rate, and it is payable in 1 year.

Insured loans. A new program of federally insured loans modeled on the Office of Education's guaranteed loan program is authorized in fiscal year 1978 for health professions and public health students. Students of medicine, osteopathy, dentistry, veterinary medicine, podiatry, optometry, and public health could borrow up to $10,000 a year and a total of $50,000. Pharmacy students, who would be eligible only after completion of 3 years of training, could borrow up to $7,500 a year and a total of $37,500. Eligible lenders could include a health professions or public health school, a State agency, a financial or credit institution, or a pension fund. Interest would be payable by the student throughout the life of the loan at a rate not to exceed 10 percent plus up to 2 percent a year for loan insurance. The principal would be repayable over a 10–15 year period starting 9–12 months after completion of training. Payments of principal would not be required, however, during periods of up to 3 years of internship or residency training or service in the Armed Forces, NHSC, Peace Corps, or Volunteers in Service to America (VISTA). At the Department's discretion, borrowers may enter into agreement with DHEW for repayment of loans, plus interest, at a rate of not more than $10,000 a year for each year of service in the NHSC or in private practice in a manpower shortage area. The minimum service period is 2 years.

Financial need scholarships. A new program of scholarships to first-year health professions students of exceptional financial need is authorized in fiscal year 1978. The scholarships, which will be awarded by health professions schools, will be equal in amount to NHSC Scholarships but without a service obligation.

Lister Hill Scholarships. At least 10 Lister Hill Scholarships a year are authorized for medical students who agree to enter family practice in a health manpower shortage area. A scholarship student will receive up to $8,000 a year for 4 years.

Health professions loans. The unconditional Health Professions Scholarship Program is being phased out, but the Health Professions Student Loan Program is continued with changes. Beginning October 1, 1977, medical and osteopathic students who will graduate after June 30, 1979, must have "exceptional financial need" to receive loans. The maximum health professions student loan will be changed from $3,500 a year to $2,500 plus the cost of tuition. The interest rate on Health Professions Student Loans will rise from 3 percent to 7 percent. Recipients of Health Professions Student Loans are no longer prohibited from receiving National Direct Student Loans from the Office of Education.

Loan repayments. The Health Professions Student Loan Repayment Program has been modified to apply only to Health Professions Student Loans. Graduates who serve in shortage areas may obtain repayment of up to 85 percent of loans at the rate of 60 percent for the first 2 years, the minimum service period, and 25 percent for the third year. Other loans may no longer be repaid under this program.

Underscoring the emphasis on student assistance is a "funding-trigger" in the legislation. Under this provision no funds may be used for any program under Title VII (the HPEA authorities) of the PHS Act in fiscal years 1978–80 unless the amounts appropriated for NHSC Scholarships and for first-years students of exceptional financial need are at least (*a*) the amounts authorized to be appropriated for those programs or (*b*) 50 percent of the total appropriations under Title VII, whichever is less.

This "trigger" does not apply, however, in any year in which less than 75 percent of the sums authorized for medical, osteopathic, and dental capitation grants are actually appropriated.

Area health education centers. Area health education centers (AHECs) have come to be favorably regarded by Congress as a means of improving health manpower in shortage areas. "These programs," the Senate Committee on Labor and Public Welfare reported, "can contribute to the effort to improve health services in rural and inner-city areas. For this reason, while the broad Health Manpower Education Initiative Award authority is not continued . . . authority for the continuation and expansion of the AHEC program is included" (*6*). AHECs link medical schools with community facilities in an effort to train health students and residents in remote sites and provide continuing education for health professionals and health education programs for the public. New authority is added in fiscal year 1978 for contracts with schools of medicine and osteopathy to plan, develop, and implement AHEC programs. At least two other health science disciplines must participate. At least one center in any AHEC program must provide for or conduct a medical residency training program in family medicine or general internal medicine with no fewer than six persons in first-year positions. A physician's assistant or nurse practitioner program also must be included.

New health practitioners. Another approach taken to increase the availability of health services is the provision of new authority for training of physician's assistants (PAs) and expanded function dental auxiliaries (EFDAs). By carrying out duties once performed solely by physicians and dentists, these new types of health personnel allow practitioners to perform more efficiently. They also can provide valuable support, Congress believes, "to the decisions of physicians and dentists to practice or remain in practice in underserved areas" (*7*). Beginning in fiscal year 1978, grants or contracts are authorized to schools of medicine, osteopathy, and dentistry and other public or nonprofit entities to support the training of PAs and EFDAs. Awards also are authorized to assist the training of dental students in the organization and management of multiple auxiliary dental team practice. These programs must conform to regulations which DHEW is required to issue. Regulations must require that a program to train PAs or EFDAs be directed toward preparing students to deliver health care (or assist in provision of dental care). A program must last at least 1 school year and consist of supervised clinical practice and at least 4 months of classroom instruction. A program must have a minimum enrollment of eight students as well as a means of placing its students.

Public Health Support

The purposes of Federal support of public health training have been narrowed and defined more explicitly. Formula grants for schools of public health will be replaced by capitation grants. Training in health administration is stressed to focus on "the shortage of appropriately trained managers throughout the health system and the inadequacy of current training resources to solve that problem" (*6*). The changes go into effect in fiscal year 1978.

Special projects. Public health special project grants will be awarded to assist accredited schools of public health and educational entities (including schools of social work) with accredited graduate programs in health administration, health planning, or health policy analysis and planning to meet the costs of developing programs in four areas: (*a*) biostatistics or epidemiology; (*b*) health administration, health planning, or health policy analysis and planning; (*c*) environmental or occupational health; or (*d*) dietetics and nutrition.

Public health traineeships. These purposes are reemphasized in the public health traineeship program. Of the amounts received by accredited schools of public health for traineeships, at least 45 percent in fiscal year 1978, 55 percent in fiscal 1979, and 65 percent in fiscal 1980 are to go to students with previous postbaccalaureate degrees or 3 years' work experience in health services who are studying (*a*) biostatistics or epidemiology; (*b*) health administration, health planning, or health policy analysis and planning; (*c*) environmental or occupational health; or (*d*) dietetics or nutrition.

Health administration grants. Grants for graduate programs in health administration are authorized to public or nonprofit private educational entities, including schools of social work but excluding schools of public health, to support educational programs in health administration, hospital administration, and health planning. Programs must have at least 25 graduates a year and spend at least $100,000 in funds from non-Federal sources. Pro-

grams also must increase first-year enrollment in the 1978–79 school year by 5 percent over 1975–76 or, if enrollment exceeds 100, by 2.5 percent or 5 students, whichever is greater. Waiver of the enrollment increase requirement is permitted if compliance will prevent the school from meeting accreditation standards. Grant applications must be reviewed by the National Advisory Council on Health Professions Education. The amount of a grant is to equal the program's appropriated amount divided by the number of eligible applicants.

Health administration traineeships. Health administration traineeship grants are authorized to public or nonprofit private educational entities, excluding schools of public health, with accredited programs in health administration, hospital administration, or health policy analysis and planning. Of the amounts received by grantees, at least 80 percent is to go to students with previous postbaccalaureate degrees or 3 years' work experience in health services.

Allied Health Assistance

Special projects. The direction of Federal support for allied health manpower programs is more specifically delineated in the new health manpower legislation. Beginning in fiscal year 1978, allied health special project and special improvement grant authorities are consolidated into new authority designed to promote six major purposes. The new special project program authorizes grants and contracts to assist in establishing:

- A regional or State system for the coordination and management of education and training at various levels for allied health personnel and nurses in educational institutions and their clinical affiliates to assure that the needs for allied health personnel and nurses in the area are substantially met;
- New roles and functions for allied health personnel and methods for increasing the efficiency of health manpower through more effective utilization of allied health personnel in various practice settings;
- New or improved methods of credentialing allied health personnel, including techniques for appropriate recognition of previous training or experience, developed in coordination with the program under Section 1123 of the Social Security Act (Section 1123 requires DHEW, in establishing qualifications for health personnel under the Medicare program, to develop methods to determine the proficiency of persons who do not otherwise meet formal requirements for performing the duties of various types of health care technicians and technologists);
- Methods of recruitment, training, and retraining of allied health personnel;
- Career ladders and programs of advancement for practicing allied health personnel;
- Continuing education programs for practicing allied health personnel.

Eligible entities include educational entities that provide for allied health personnel education and training and that meet specified standards; States, political subdivisions of States, or regional and other public bodies representing States or political subdivisions of States; or any entity having a working arrangement with such an educational entity. Of the amounts appropriated for special project grants and contracts, 50 percent is to be reserved for awards to training centers for allied health professions.

Traineeships and disadvantaged support. Authority for grants to institutions for advanced traineeships in allied health is extended with eligibility limited in fiscal year 1978 to personnel being trained as teachers, administrators, or supervisors. An existing program of educational assistance for disadvantaged students in allied health fields is replaced by new but similar authority.

Foreign Medical Graduates

The influx of foreign medical graduates was viewed by Congress as a "sensitive national issue" in the debate over the new health manpower legislation. In the past decade this country imported about as many physicians as it graduated. Approximately one of every five practicing physicians is an FMG. If the trend continues, one of every three U.S. physicians would be an FMG by 1990.

In the declaration of policy in the new legislation, Congress stated that "there is no longer an insufficient number of physicians and surgeons in the United States such that there is no further need for affording preference to alien physicians and surgeons in admissions to the United States under the Immigration and Nationality Act" (*1*). The HPEA Act of 1976 revises the Immigration and Nationalty Act to restrict the entry of FMGs.

Foreign physicians wishing to enter the United States as immigrants must pass Parts I and II of the National Board of Medical Examiners examination (or an equivalent examination as determined by

DHEW) and be competent in written and oral English. These requirements also apply to FMGs wishing to enter the country as exchange visitors (with J Visas) to receive graduate medical education or training. Moreover, a school of medicine and affiliated hospital must agree in writing to provide (or arrange for provision of) the training for a physician on a J Visa. And an exchange visitor must be committed to return to his country upon completion of training. Under these provisions, Rep. Harley Staggers, chairman of the House Interstate and Foreign Commerce Committee, noted, "the United States will still be a valuable international resource for the training of qualified alien physicians but our reliance on poorly trained FMGs will cease, and physicians who are much more badly needed in their countries of origin will no longer be encouraged to abandon their countries to practice medicine in the United States" (*7*).

The new regulations went into effect January 10, 1977. But the rules respecting exchange visitors may be waived by the Attorney General until December 31, 1980, if there would be a substantial disruption in the health services provided by the graduate medical education program in which an FMG seeks to participate. DHEW has determined that implementation of this provision would cause substantial disruption of health services and recommended to the Department of State and Justice that waivers be granted to exchange visitors for a 1-year period.

U.S. citizens. Special attention is given in the law to U.S. citizens studying at foreign medical schools. It has been estimated that there are at least 6,000 American students, unable to gain entry to U.S. medical schools, who are enrolled in foreign schools. The new law requires U.S. medical schools, as another condition of capitation, to reserve a number of places in their classes for American students studying in foreign schools. Also, special project support is authorized for schools of medicine and osteopathy to train American students who have transferred from foreign medical schools. Only students who attended foreign medical schools prior to October 12, 1976, are eligible to participate in these programs.

The provision requiring U.S. schools to absorb transfers is not intended to encourage U.S. students to seek a foreign education if they intend to practice medicine in the United States, according to Rep. Paul Rogers, chairman of the House Health Subcommittee. "It is intended to remedy an unfortunate situation . . . in which thousands of U.S. citizens are presently enrolled in foreign medical schools in which, in most cases, the education they are receiving is not of the quality provided by U.S. medical schools . . ." (*7*).

Other Significant Provisions

Disadvantaged assistance. Among other significant concerns addressed by the HPEA Act of 1976 is the persistent underrepresentation of minority and low-income students in health professions schools. Despite substantial improvement in the past 6 years, the racial and socioeconomic composition of health professions students is still in need of better balance if the equality of access to a health professions career is to be assured, Congress declared. The 1976 law extends the program of support of projects to recruit disadvantaged students into health professions training. The new special project authority continues to focus on identifying individuals, facilitating their admission into school, and providing counseling and preliminary education.

Occupational health training. A new provision for occupational health training centers was introduced into the law as a result of the Senate's concern over "the enormity of occupational illness, death and disability" and the lack of personnel trained to cope with the problem (*6*). The law established new authority beginning in fiscal year 1977 for grants to public or private nonprofit colleges or universities to establish occupational health training and education centers through cooperative arrangements between medical schools and schools of public health or other schools or departments in a university. Congress envisaged establishment of 10 occupational health training centers, one in each DHEW Region. The occupational health training center provision will be administered by the National Institute of Occupational Safety and Health, part of the Center for Disease Control.

Manpower data. Substantially more information about the nation's health manpower resources is expected to become available as a result of the new law. DHEW is required to collect, compile, and analyze health professions data which initially will concern physicians and dentists but may be expanded as needed to cover other health personnel. Grants or contracts may be awarded to States or appropriate nonprofit private entities to establish a uniform health professions data reporting system. DHEW is to report yearly to the President and

Congress on the status of health professions personnel. Other sections of the new law require the Department to undertake broad data collection activities and issue several reports on allied health personnel and annual reports on public health and community health personnel.

Financial reporting. Financial reporting procedures are being tightened for recipients of Federal funds. With the exception of students, all recipients of financial aid under the HPEA law must keep such records as DHEW is to prescribe to facilitate an audit conducted according to generally accepted standards. Every grant or contract recipient must provide for an annual audit of records, and the Department and the Comptroller General are to have access to the audits and records.

Tuition. Under another new requirement, DHEW is to establish criteria to determine allowable tuition and educational cost increases for which the Department is to be responsible for payment under any program authorized by this law. The provision applies primarily to the NHSC Scholarship, financial need scholarship, insured loan, and Health Professions Student Loan Programs. "Tuition costs are reimbursed at 100 percent under both the scholarship and loan titles of the reported bill," the Senate Committee on Labor and Public Welfare noted. "Total program costs could soar uncontrollably if patient care and research costs were inappropriately built into tuition. One of the important lessons of Medicare is that cost-plus reimbursement, by which hospitals are essentially reimbursed for any and all costs that they incur, has contributed to the cost of health care; the Committee is determined to avoid this pattern in its support of medical education" (*6*).

General special projects. The broadest authority in the HPEA Act of 1976 is contained in a new general special projects section effective in fiscal year 1978. It authorizes support for more than 20 types of projects including interdisciplinary training; bilingual health clinical training centers; health manpower development; environmental health education and preventive medicine; regional systems of continuing education; computer technology; humanism in health care centers; curriculum development in schools of optometry, pharmacy, and podiatry; special medical problems related to women; training health professionals in human nutrition; and training in medical and behavioral problems of the aged.

Implementation

The Bureau of Health Manpower began carrying out the new HPEA legislation on the day of enactment. A few provisions went into immediate effect. Operation of a fiscal year 1977 program cycle, as modified by the new legislation, has begun. Preparations are under way to launch new and modified programs for fiscal year 1978.

A major issue in carrying out the law is the requirement for recentralization of health manpower programs. HEW Regional Offices are prohibited from reviewing any application for a grant or contract under title VII for the purpose of presenting it to the National Advisory Council on Health Professions Education. They also are prohibited from awarding such a grant or contract. Regional Offices will continue to have responsibilities for technical assistance and monitoring projects.

What does Congress hope this legislation will accomplish in future years?

The HPEA Act of 1976 is designed, according to Representative Rogers, one of its principal authors, "to reverse several critical trends in the American health care system today and will chart the course for health care delivery through the next decade. It will reverse the geographical maldistribution of health manpower and provide needed health care services to underserved populations. It will reverse the pattern of specialty maldistribution and increase the number of primary care physicians in this country." (*7*).

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